Indiana Department of Insurance
311 W. Washington Street, Ste. 300
Indianapolis, IN 46204-2787

Preferred Provider Plan Reporting

I.C. 27-8-11-5 requires each person that organizes a preferred provider plan under this chapter shall file with the commissioner before **March 1** of each year a statement, under oath, upon a form prescribed by the commissioner that covers the preceding calendar year and includes the following:

1.	Person who organized the Preferred Provider Plan:	
	Preferred Provider Name:	
	FEIN# for Preferred Provider Network:	
	Preferred Provider Address:	
	Telephone Number:	
	Contact Person:	
	Contact Address:	
	Contact Telephone #:	
	State of Domicile:	

2. Attach a listing that includes the names and addresses of the providers with whom the preferred provider plan has entered into agreements.

3. Attach a listing of counties (**by name**), within which the preferred provider plan provides or arranges for health care services for insureds, members or enrollees.

4. The number of Indiana insureds, members or enrollees covered by the agreements listed in subdivision (2). _____

5. Attach a listing of insurers and health maintenance organizations using the Preferred Provider Plan.

Dated and signed this _____ day of _____, 20___ at _____.

I hereby certify under penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

_____ _____
Signature Title

_____ _____
Typed Name Date

Personally appeared before me the above named _____ personally known to me, who, being duly sworn, deposes and says that he/she executed the above instrument and that the statements and answers contained therein are true and correct to the best of his/her knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____
Notary Public County and State of Residence

My Commission Expires _____